RETURN TO WORK ACKNOWLEDGEMENT

Employee Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Incident/Accident Date: __________ **Department:** __________

Dates for Temporary Modified Duty: ____________________

List restrictions as noted by physician **(attach physician's documentation)**. It is understood that any modifications to the restrictions may only be changed by the attending physician.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

List any accommodations being provided; a separate sheet to document conditions, expectations, and requirements for this temporary modified duty assignment may be added.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

I understand that I am required to follow my physician's restriction(s) and that the restriction(s) have been discussed with me. I also understand that I am required to work safely and perform my duties in a manner that is consistent with the performance standards set forth by Montgomery County Government. I understand that failure to follow these restrictions could terminate my On-The-Job Injury and employment rights.

____________________	__________	____________________	__________
Employee Signature	Date	Supervisor's Signature	Date